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AUTHOR Koocher, Gerald P.
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ABSTRACT

Professional competency in psychologists wishing to treat children and families is an area of considerable concern and disagreement. Three types of practitioners comprise the bulk of the problem: clinical psychologists, who lack specific child-oriented training; developmental psychologists, who wish to serve children but lack traditional clinical training; and developmental psychologists, who lack clinical training but are currently serving children. The American Psychological Association's (APA) Standards for Providers of Psychological Services recognizes the single route theory to competency, which maintains that retraining in a formal program integrating formal classroom and experiential preparation, is the only true road. Recently, however, representatives of APA and its divisions have recognized that psychologists may become health care providers by a variety of routes, adopting a broader, three-component definition of clinical psychologist which includes state licensure, doctoral degree in psychology from a regionally accredited institution of higher learning, and a 2-year internship in a health service setting. Training deficits or competence gaps currently exist either in classroom or experiential preparation; single route theorists believe that these must be acquired simultaneously in an integrated fashion. However, many graduates of APA approved programs lack either theoretical or clinical training in developmental psychology. To ameliorate the competence gap, the credentials and competencies of individual psychologists should be reviewed and specific goal-oriented remedial work should be undertaken. To assist in this endeavor a new organizational division within APA is recommended: the Bureau of Academic Retraining Facilities. APA-approved internship sites are also recommended, designated as Technical Uniform Retraining Facilities. (BL)

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COMPETENCE IN SERVING CHILDREN: CREDENTIALS PROTECTIONISM AND PUBLIC POLICY

Gerald P. Koocher

Children's Hospital and Judge Baker Guidance Center

Boston, Massachusetts

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ABSTRACT

This article examines current controversies regarding the qualifications needed by individual practicioners who wish to provide services to children and families. Special attention is focused on the clinician trained to serve adults and the developmental psychologist who wishes to acquire applied training. Current policy is contrasted with practical problems and the controversies are discussed from the perspective of a child-oriented internship training site. A new model for providing specialized professional retraining for the adult-trained clinician and developmental psychologist is proposed.

Competence in Serving Children: Credentials, Protectionism, and Public Policy

The practice of psychology is now regulated by law in fifty states and the District of Columbia. A host of would-be regulators of psychological practice regularly contend with each other over policies of who should deliver what type of services to whom. Those concerned with providing high quality mental health services to children, youth, and families have often felt somewhat frustrated that certain critical issues are being ignored. Perhaps this results from the considerable disagreement about what constitutes a core training program in psychology, or precisely how to identify programs which properly train psychologists. There is some logic to the notion of solving those problems before turning to the special issues involved in credentials to serve children. On the other hand, sufficient structures and agreement now exist to warrant exploration of some of these special education and training issues now.

This paper addresses two related questions. First, what credentials are necessary and sufficient in order to presume that a practitioner is qualified to treat children? Second, what should be done about those psychologists who wish to provide services to children and families, but are prevented from doing so by their lack of a specific credential? This paper includes a discussion of the credential questions as well as proposing specific remedies to assist those lacking the most valid credentials.

What are the issues?

There are essentially three types of practitioners who comprise the bulk of the problem. First, are those psychologists trained as human service providers (e.g. clinical or counseling psychology graduates) who want to serve children or families, but have no specific child-oriented training. Second, are those psychologists with degrees in developmental psychology, child development, or human development who want to serve children or develop applied skills, but do not have traditional clinical or counseling training. Third, are those psychologists in the previously mentioned groups who begin evaluating or treating children or families without specialized training.

Psychologists in this latter category are clearly in violation of the Ethical Principles of Psychologists , especially Principle 2 (competence) and Principle 6 , (welfare of the consumer). Unfortunately, they are not likely to get caught unless or until they make serious mistakes. That is to say, the public is unlikely to recognize their incompetence from the outset and enforcement bodies such as ethics committees or licensing boards are not likely to catch them until a serious problem leads to a complaint. Even when they are caught, enforcement is hardly certain (Hogan, 1979; Koocher, 1979).

It is easily possible to finish an APA-approved doctoral program in clinical or counseling psychology, for example, without ever seeing a child client or taking a course in developmental psychology. Many psychologists practicing family therapy

have never studied developmental psychology or child psychopathology. Too often psychologists who have completed their doctorates and licensure requirements seem to have the attitude that they can read a book or take a workshop on a new technique or treatment modality and go use it in their practices. Because of their relative lack of insight with respect to their own competencies and weaknesses, such colleagues are unlikely to step forward and identify themselves. While it is worth noting that they exist in all too significant numbers, they are not the prime focus of this paper. The best means to influence this sort of ethical misconduct is by improving the teaching of professional ethics in graduate programs, so that such values are inculcated in students at their most formative stages. The immediate focus here is on psychologists who recognize their competence gaps and want to address them.

The "Adult" Practicioner

The "adult practicioner is the psychologist who never got child or developmental training and knows that (s)he needs it to practice with the client population (s)he sees. These psychologists recognize their need for additional specialized training, but are not often sure of the appropriate components. If they do know the proper components, they may not know where to acquire these. If they do know what they need and where to get it, they may find the new competencies difficult to acquire for a variety of additional reasons. Not the least of these may be the economic cost of pursuing a training program full-time in mid-career.

The Developmentalist

The developmental psychologist who wants to learn "clinical," "counseling," or other applied skills is often immediately regarded with suspicion by practicioner colleagues. Developmentalists may be cast as "trying to sneak in the back door" or as intending to be designated a clinician by non-traditional means. Such views tend to be predicated on a single route to competence assumption, which is discussed below. In any case, such psychologists must also identify and then locate appropriate and valid training, while facing similar economic burdens to the so-called "adult" practicioner. The developmentalists are, however, at some specific disadvantage by virtue of the traditional views of applied training noted above.

Retraining or Competence Building?

American psychology has officially addressed the problem of the developmentalist, while ignoring the "adult" practicioner. A specific mechanism in the form of retraining or so-called "retread" programs has emerged with detailed policy recommendations (APA, 1976; 1977). Psychologists who wish to switch from being a developmental psychologist to a clinical, counseling, or school psychologist are told what to do:

> "Go back to school. Go to a program specially designed to retrain psychologists and fulfill all of the formal requirements of the degree you seek, which were not a part of your initial doctorate in psychology."

Candidates are told to expect that they will be given due credit

for previously satisfied coursework requirements and are cautioned that a mere internship or practicum experience does not constitute adequate retraining (APA, 1977, p.6).

Although the APA Council hoped to encourage universities and professional schools to offer such programs the response has been underwhelming. The most recent data available through APA (Woodring, Note 1) suggests that 43 formal programs of the retread variety exist with 23 of these being clinical in nature. Among this group there are probably less than 200 openings per year, and most of the programs require two to three years of full-time study. Tuition is substantial in such programs, since the nature of the teaching components and necessary practica generally require low student to faculty ratios.

The current system obviously makes it quite difficult for a psychologist in mid-career to change specialties. Woodring (Note 1) also noted the special problem of the senior psychologist who trained at a time (years ago) when current requirements had yet to be formulated. She notes that there are many such colleagues, who prefer to remain anonymous, who are boxed into an interesting paradox. They regularly teach students in clinical or counseling courses at advanced levels, but under current credential restrictions are not permitted to practice what they are teaching others to practice. While this incompetence to practice is a technical presumption of questionable validity, it is nonetheless built into many credentialing systems in psychology.

Is Retraining Necessary?

Current policy as articulated in the APA's Standards for Providers of Psychological Services (1977) is directed toward clinical, counseling, and school psychology. These policies imply that retraining in a formal program is the only true road to practicioner competence. I refer to this assumption as the "single route theory." It clearly exists as a professional ideal in defiance of empirical reality. There are many competent clinicians who acquired their skills in other ways, including virtually all of those who trained in the 1940's and 1950's, when clinical psychology was in its infancy and toddlerhood. It has been argued that current credentials in psychology hold little predictive validity for competent professional practice (Gross, 1978; Hogan, 1979; Koocher, 1979), and the Standards for Providers of Psychological Services make no pretense of assuring competence.

While professional standards may provide some low-level protection against outright quackery, there is little or no evidence of their validity as guides to practicioner competence. The notion that a single prescribed type of program is the sole route to develop professional skill for highly specific service applications flies in the face of common sense. Consider this example:

> A traditionally trained graduate of an APA-approved program in clinical psychology and an APA-approved internship (both of which included child-clinical experience and developmental psychology coursework) routinely per-

> forms psychodiagnostic assessments on children. This psychologist routinely writes reports with educational recommendations directed toward the schools where his/her clients are enrolled.

There is noting unusual about this, many child clinicians do it every day, the APA's Standards for Providers of School Psychology Services quite directly suggest that this behavior is of questionable propriety, because the training did not come via the single acceptable route to competence for such services: a school psychology program.

Consider a more dramatic example:

> A senior developmental psychologist has devised a well-standardized developmental assessment scale for use in evaluating the cognitive, social, and motor skills of infants and toddlers. The test is well published and has received considerable favorable review from psychometric and clinical experts.

According to the same Standards for Providers documents cited above, it would be inappropriate for that psychologist to come into a clinical setting and conduct an assessment with the very instrument (s)he devised and standardized. At the same time, it would be appropriate to send a graduate student (sic: psychology intern) off to test a child using the same tool.

The implication that the clinician in the first example is

not qualified to consult with schools, or that the developmental psychologist in the second example is not competent to use her/his own instrument in a clinical context derives from the "single route theory." That is to say, neither of the psychologists specified took the sole path recognized in APA policy statements as the road to competence. It does not seem to matter to the crafters of these policies that they are without empirical validity.

One step in the right direction is the recognition that psychologists may become health care providers by a variety of routes. This was implicit in a meeting held among representatives of APA and its divisions interested in securing coverage for psychological services under all federal health care programs. The "executive summary" of the so-called "Greenbriar Conference," suggests a new meaning for the term 'clinical psychologist.' A three component definition was proposed: first, is licensure or certification at the independent practice level by a state. The second element is an earned doctorate in psychology from a regionally accredited institution of higher learning. Finally, the proposal would require two years of supervised practice in a health service setting, at least one of which is post-doctoral (Note 2). Note that no doctoral specialty or specific internship rules are cited.

This definition is an important step, although it fails to recognize an entire class of individuals trained in departments which are named something other than "psychology," even if the curricula are fully congruent with psychology degrees. For ex-

ample, a person functioning as a developmental psychologist trained in "human development" or "social relations" would be excluded under the proposed rules. Interestingly, some of the nation's most distinguished psychologists have trained others or been trained in departments by those titles at Harvard University for many years.

The important question will not be how to turn developmental psychologists into child clinicians or school psychologists, but rather how to provide the non-clinician with the skills necessary to perform some valuable health services competently. Likewise, we must find a reasonable means to help the "adult" clinician who so-desires to acquire child assessment and intervention skills in a more reasonable manner than currently exists.

Horror Stories

One characteristic of the "single route" theorists is to conjure up horror stories of abuses perpetrated on clients or of unqualified psychologists sneaking in the "back door" to practice as clinicians. The abuse stories can be countered case for case by psychologists who have served on ethics committees and have encountered numerous cases of gross ethical misconduct on the part of colleagues with all the "right" credentials. As for the "back door" stories, the tellers of the tales are prone to omit significant details which others might deem of crucial relevance. One recent paper by Orgel (1983) provides a superb example. A direct quote of his "back door" horror story follows:

"Incident 2) A young man has an MSW degree. He

> attends a nonregionally accredited free standing school of psychology which is, of course, not APA-approved. He obtains a doctorate in psychology but because of the unacceptable quality of his training (a non-regionally accredited school) he is denied admission to the licensing exam in a Northeastern state. The denial is overturned by the next level of authority of the state on appeal of the applicant. The rationale provided by this state's authority, which admits the young man to the licensing exam, is that he obtained a year of internship training at a prestigious Ivy League medical center Psychology Internship site, and the state authority insists that the internship center reviewed his educational credentials and found them acceptable." (p.6)

Amazingly, we had a very similar student in our internship program a few years ago. The story is virtually identical to the portion presented by Orgel, with a change in detail and a few rather substantial omissions. First, the student in our program was a middle-aged woman. Apparently age and sex were Orgel's attempts at disguising the case. Orgel neglects, however, to mention the following facts. She has worked as a senior social work supervisor and therapist for more than a dozen years at a prestiegous west coast neuropsychiatric institute, before return-

ing to graduate school. The school she attended was accredited at the state level and had a solid reputation for a strong psychology faculty. Her competence and practice skills were highly praised by all of the psychologists involved in her training, including those at internship and practica sites. The woman took and passed the nationally administered licensing examination with high grades and was subsequently licensed in two states (including one which required additional essay and oral examinations). She completed additional training in psychoanalysis and developmental psychology, and was offered a staff position and medical school faculty appointment at the "prestigious Ivy League medical center" after completing her internship there.

It was only after all of these accomplishments that she sought licensure in the "Northeastern state" referred to by Orgel in order to relocate and was denied admission to their licensing examination based on the state's rigid set of "single route" credential criteria. We were delighted to assist her and felt entirely justified when the higher state authority accepted the evidence and overturned the licensing board's decision. She subsequently passed the licensing examination and is now fully licensed by examination in three states. I suspect that the reader might not find the case so clear-cut or horrifying as Orgel first suggested sans the additional data offered above.

Our internship program has accepted other non-traditional candidates, in the sense that they do not meet the "single route" standard. They must compete with nearly 300 applicants from APA-approved programs from all over the United States for 15 openings

per year. Consider some of the recent candidates we accepted from developmental psychology programs:

Candidate A: Prior to entering a Ph.D. program in developmental psychology at an internationally respected university, this applicant had completed an M. Div. degree in pastoral counseling at a world renown divinity school. She had spent two years in supervised counseling work at a shelter for abused women and subsequently spent a year conducting research on the developmental assessment (cognitive, motoric, and emotional) of children with Down's Syndrome.

Candidate B: This young woman entered graduate school in developmental psychology, while working on the intra-mural staff of N.I.M.H. Her work had routinely involved her in clinical research and direct patient contact over several years. She completed practica under excellent supervision at several sites in the Virginia-Maryland-D.C. area prior to applying to our program, and had published three important papers with strong clinical relevance in peer-reviewed journals.

Candidate C: Another applicant entered our program as a "pre-doctoral intern" after

completing her doctorate in developmental psychology. She had accumulated nearly three years of experience in consulting to management organizations and a variety of practica prior to being accepted. She was fully qualified for state licensure at the time she entered the program and actually completed the examination process and was licensed four months into the internship.

It is worth noting that all three of the applicants cited above were women. While we have also accepted males with similar credentials, it seems that a high proportion of the applicants who may be seeking such applied training from developmental psychology backgrounds will be female. While beyond the scope of this paper, it is worth considering whether sexual bias plays a role in solidifying the barriers these women must challenge.

Some of the candidates we have taken from non-traditional "single-route" pathways are among the best trainees we have had. Internship sites would be foolish to accept less than fully qualified applicants, since to do so would put them at increased risk for malpractice actions, cost considerable time in remedial work, and generally reduce the quality of services offered. We routinely turn down applicants from APA-approved programs who are not ready in our view, despite the fact that their clinical training directors have certified them as prepared for internship. One such program was prepared to send out on internship a

student who had completed only four clinical assessments in three full years of graduate school. Another two programs we are familiar with do not routinely teach their students to administer and interpret projective personality assessment techniques. All of the developmental students we have accepted not only had completed projective testing courses, but they had also completed a substantial amount of assessment training.

Competence Gaps

There are basically two types of training deficits or competence gaps between the well-qualified service provider and the person with inadequate preparation. These might best be termed classroom and experiential preparation. By classroom preparation, I refer to the theoretical and factual knowledge acquired by supervised readings, classroom instruction, monitored research, and other such didactic activities normally associated with university settings. The term experiential as I use it is intended to convey supervised "hands on" clinical activity such as practica and internship placements, during which the learning process is augmented by the direct personal experience of serving clients under supervision.

"Single route" theorists have generally asserted that these two types of training must be acquired simultaneously in an integrated fashion. At the same time, the current integrated system has failed to "integrate" skills critical to the provision of quality children's services at the university level. As noted earlier, many graduates of APA-approved clinical psychology

programs routinely exit their universities never having participated in coursework on cognitive and emotional development in childhood, child psychopathology, or theoretical background in child and family treatment. Our applicants have often had no training in specialized play or assessment techniques and are often unfamiliar with such instruments as the Bayley, Merrill-Palmer, and McCarthy Scales for infants and toddlers. Many have never administered any of the specialized projective instruments designed for use with children, and few have a sense for how some tests traditionally used with adults vary in application with children.

A Modest Solution

The potential for a simple solution seems easily within our grasp if the APA wishes to help bring it about. The proposal is modest in terms of cost and lack of pretense, but it will be controversial because it challenges the predominance of the "single-route" theorists. The basic value of the proposal rests on a single pivot point: the best public service psychology can offer the consumer is a competent practicioner and competence is not limited to those trained in traditional programs.

Recognizing the two basic components of professional training discussed above, it should be possible to examine the credentials and competencies of an individual psychologist and to recommend goal-oriented remedial work. For example, the developmental psychologist who wishes to acquire applied training is likely to have completed many courses appropriate to child work along the

way to his/her doctorate in psychology. The psychologist would need some means to analyze the competencies already acquired, specify those which are needed, and begin to obtain the needed skills. Some of the needs would include coursework and some practica or internship work.

A new organizational entity within the APA Educational Affairs Office might be of assistance. One possible name for the new body would be the Bureau of Academic Retraining Facilities (BARF). BARF would serve three functions. First, it could provide a means for reviewing the competencies of applicants and reframing these with respect to candidates' practice goals. Second, it could offer a means of tracking the progress of applicants toward the completion of those goals and of documenting the completion if/when it occurs. Finally, BARF could set up a means within which the specific retraining may occur.

Many universities would be interested in opening enrollment to certain courses which led themselves to classroom format (e.g., childhood psychopathology, lifespan developmental psychology, theories and systems of psychotherapy, etc.). These are courses which the applicant referred by BARF might need. By permitting occasional students to enroll for a course or two on a non-degree basis, universities could raise needed additional revenue at minimal additional overhead costs. The courses would be given anyway, and enrollment of a few extra students to third type of a course does little to reduce the overall quality of the experience.

The costly courses from the university's standpoint are those specialized technique or practicum courses which must be offered as part of certain degree programs, but must of necessity be kept to a low student to faculty ratio. These courses might include psychodiagnostic assessment, psychotherapy practica, etc. universities would not want to open such courses up to non-degree candidates or substantially increase enrollment.

On the other hand, a nationwide system of APA-approved internship placement sites now exists. Many are also approved as sponsors of continuing education programs by APA. Some of these sites might be willing to develop practicum programs or specialized technique courses to supplement the university-based courses specified by BARF. Such facilities could be organized, inspected, and accredited by BARF and designated as Technical Uniform Retraining Facilities (TURF).

Financing of the program would be relatively economical. Psychologists seeking the advice and assistance of BARF would pay a reasonable charge for the evaluation and consultative services. Universities or applied training settings wishing to qualify as TURF would also pay a fee for being accredited and would submit to appropriate accreditation, site visits, and reporting guidelines. Psychologists could enroll at any appropriate TURF willing to accept them and would be expected to pay tuition to the facility. The TURF programs would be able to finance the additional trainee programs through tuition funds, and could set their own bases for accepting candidates approved in advance for such training by BARF.

While this paper has advanced the argument of special need for retraining opportunities in the case of children's services, the model proposed above is obviously generalizable. It is competence focused and free of restrictions growing out of unvalidated guild issues. Unfortunately, for many psychologists the real issues are narcissism and economics, although few are as willing as Richards (1983) to be open about the bottom line. He notes:

> "Retail stores have customers, attorneys have clients, but I consider myself a doctor and I treat patients...We are continuing to have a problem regarding a basic law of economics and supply and demand...It is also disgusting that people spend four to five years getting a doctorate, go through an internship, and are offered a job for 20K." (p.6)

We cannot afford not to facilitate the availability of competently trained practicioners, especially where our children are concerned. My advice to Dr. Richards and those who think as he does is to go get an M.B.A.

Reference Notes

Note 1. Woodring, J. Personal communication, August 10, 1983.

Note 2. Executive Summary, Greenbriar Meeting on Medicare, February 25, 1983.

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